Kansas Department on Aging

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046049	A. BUILDING: _____ B. WING _____	C 03/28/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON GARDENS OF PRAIRIE VILLAGE	7105 MISSION ROAD PRAIRIE VILLAGE, KS 66208

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S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS63906.	S 000		
S3110 SS=J	26-41-203 (a) Range of Services (a) Range of services. The administrator or operator of each assisted living facility or residential health care facility shall ensure the provision or coordination of the range of services specified in each resident ' s negotiated service agreement. The range of services may include the following: (1) Daily meal service based on each resident's needs; (2) health care services based on an assessment by a licensed nurse and in accordance with K.A.R. 26-41-204; (3) housekeeping services essential for the health, comfort, and safety of each resident; (4) medical, dental, and social transportation; (5) planned group and individual activities that meet the needs and interests of each resident; and (6) other services necessary to support the health and safety of each resident. This REQUIREMENT is not met as evidenced by: The facility reported a census of 23 residents living on the Reminiscence, memory care unit. The sample included 3 residents. Based on observation, record review, and interview the facility failed to provide care and services to safeguard 1 of 3 sampled residents (#1 a closed record) who eloped from the facility and had a fall which placed this cognitively impaired resident in immediate jeopardy when he/she left the facility without staffs knowledge.	S3110		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S3110	Continued From page 1 Findings included: - The physician's History and Physical dated 1/7/13 recorded resident #1 had Dementia, (a progressive mental disorder characterized by failing memory and confusion). Review of the resident's Service and Health Assessment dated 1/7/13 recorded the resident required limited assistance with mobility, grooming, dressing, bathing, and toileting and was independent with transfers and dining. The updated resident assessment dated 2/15/13 recorded the resident had increased need for safety due to he/she was more incontinent and would pace from one door to another door to the outside. The assessment documented the resident had an inpatient psychiatric visit to a local hospital due to he/she hit another resident, was difficult to redirect, and had an increased risk of elopement. This same assessment recorded medication adjustments for the resident were managed at the hospital, and the resident now had good and bad days and continued to pace up and down the halls, attempted to leave the community and got upset at times, and he/she had pinched some staff. Review of the physician's order sheet (POS) revealed an order dated 5/31/12 for a wanderguard (device worn by the resident to alert staff when the resident attempted to leave the facility) due to the resident's risk for elopement. The residents individual service plan (ISP) (care plan) dated 2/5/13 documented, the resident napped frequently, was frequently up during the night, would awake several times and would	S3110		

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wander. At those times the resident experienced increased anxiety due to confusion. The ISP also recorded the resident was a high fall risk and wore a wanderguard bracelet on his/her left ankle to alert staff of attempts to leave the facility.

On 3/25/13 at 8:35 A.M. observation revealed the Reminiscence/secured Dementia care unit presented as a long hallway with locked exits at both ends and resident apartments on both sides. Observation also revealed 2 locked exits to a courtyard enclosed by a six foot tall wooden fence. The exits opened to a walkway, which ran the perimeter of the building and outside the enclosed courtyard. Observation revealed each door had a magnetic lock, a 15 second delayed opening, after which the door opened and an alarm sounded.

On 3/25/13 at 8:46 A.M. direct care staff A acknowledged that all residents on the unit had some level of confusion and several residents had exit seeking behavior.

Review of the clinical record and the facility self-report revealed resident #1 had two recent elopements from the facility.

The nurses' progress notes dated 2/15/13 at 9 A.M. recorded the resident was found yesterday evening around 6:00 P.M. laying on the ground by the bushes in the Reminiscence courtyard, the resident could not say what happened, the staff assisted the resident up and no injuries were noted.

The nurses' note lacked documentation of when staff last saw the resident, how long the resident was outside, weather conditions and/or if the resident's wanderguard alarm or any door alarms

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S3110	Continued From page 3 were activated. The facility investigation also recorded the resident's elopement to the courtyard and a non-witnessed fall report but lacked any detailed timeline and/or witness statements. This ISP lacked documentation the resident was found unattended outside the facility on 2/14/13 and/or any interventions to prevent reoccurrence. Nurses' progress notes dated 2/19/13, at 5:58 P.M. (5 days after the first elopement) revealed the resident was brought back to the community by 911 ambulance. The paramedic assisted the resident with stand by assistance and staff noted an abrasion to his/her right cheek. Staff asked the resident why he/she wanted to leave and where he/she was going, but the resident did not respond. The staff asked the resident to promise he/she would not leave, the resident shook his/her head no. The facility placed the resident on one-on-one care and did not send the resident to the hospital due to paramedics said the resident was ok. The nurses' notes and facility self-reported investigation recorded the following summary of the resident's elopement: On 2/19/13 at 5:52 P.M. the resident ate his/her supper and then was up walking the halls. Staff checked on the resident hourly, due to the resident's history of behaviors and wandering. The resident's wanderguard was in place and last checked at 5:40 P.M. An alarm from Reminiscence east side exit door alarmed. Staff proceeded to the door going to both the right and left side of the building but staff did not see a resident. Direct care Staff B initiated a head count A woman out walking observed the	S3110		

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resident walking unattended and the resident slipped on a curbed incline. The resident did not have a coat on and the citizen notified 911. 911 arrived at the scene and returned the resident to the community.

After the elopement on 2/19/13 the resident's ISP was revised to include one-on-one care.

According to Wunderground.com, on 2/14/13 the temperature at 5:54 P.M. was 48 degrees Fahrenheit (F). On 2/19/13 the temperature at 4:54 P.M. was 33.1 degrees F and the wind chill was 24.9 degrees F. The temperature at 6:54 P.M. was 28 degrees F and the wind chill was 22.8 degrees F.

On 3/26/13 at 1:35 P.M. a telephone call with the Prairie Village Police Department confirmed a 911 emergency call concerning the resident was entered at 5:45 P.M. on 2/19/13.

This information was contradictory to the facility notes documented on 2/19/13 at 5:52 P.M. whereby the resident ate supper, and then was walking the halls.

On 3/26/13 at 2:08 P.M. review of the Facility Smart Care (door alarm activation history) revealed the southeast exit on the Reminiscence care unit was activated at 5:35 P.M. on 2/19/13 and remained activated until 5:51 P.M. This same document recorded the alarm was announced (to individual staff pagers) 4 times.

These recorded entries indicate the resident was outside for approximately 23 minutes, and not 8 to 10 minutes as noted in the facility report.

On 3/25/13 at 2:50 P.M. observation revealed the

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S3110	Continued From page 5 southeast exit door on the Reminiscence care unit alarmed when opened and the hand held wanderguard used for testing sent a message to the staffs hand held pagers, however the audible alarm for the wanderguard system did not sound. At this time, direct care staff B acknowledged the door was not working properly. He/she said the staff just checked it the other day and it was working. On 3/25/13 at 2:58 P.M. observation revealed the intersection of 71st street and Mission Road (where the resident was located) was approximately 500 feet from the Reminiscence care unit's southeast exit. On 3/25/13 between 2:58 P.M. and 3:05 P.M. the surveyor revealed the timed walking distance between these two points was approximately 5 minutes. Continued observation revealed Mission Road, had a speed limit of 30 mile per hour (mph), was a 4 lane road which ran parallel to the front of the facility, while 71st street, a 30 mph 2 lane road went east and west, approximately 320 feet north of the facilities main entrance. On 3/25/13 at 2:55 P.M. maintenance staff C provided information to confirm monthly checks of the door alarm on 2/5/13 and 3/5/13 but no checks were performed on the residents' individual wanderguard bracelets. Maintenance staff C further stated, that he/she checked resident 1's wanderguard right after his/her return on 2/19/13 and it was working fine. Maintenance staff C added a local company serviced the facilities alarm system and he/she had a call in to them.	S3110		

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S3110	Continued From page 6 On 3/25/13 at 4:00 P.M. direct care staff D stated the individual wanderguard bracelets had an expiration date and when they need changed the nurse provided the device and bracelet. The facility did not check the wanderguard devices to see if they worked. Interview on 3/26/13 at 3:53 P.M. administrative staff A stated the facility did not have a policy regarding the monitoring of residents at risk for elopement. He/she stated the exit doors had a 15 second delayed magnetic alarm, that would alarm audibly and send a message to the staffs' pagers. The wanderguards on the exit doors alarmed audibly and sent a message to the staffs' pagers when a resident with a wanderguard got close to the door. Review of the undated facility policy titled Procedures for Responding to Door Alarms recorded: The emergency pagers in the Assisted Living will inform the staff of the door that alarmed. All associates were responsible for determining what caused an alarm to sound. Review of the facility policy titled Elopements; revised April 2001 directed staff to make an extensive search of all surrounding areas. The Wandering Resident Safety System policy documented that residents that wore a safety-monitoring device were evaluated at frequent time intervals during the day for placement of the device. Safety-monitoring devices were tested weekly, with results recorded on the Safety-Monitoring Device form. The Safety -Monitoring System was tested daily by the Maintenance Coordinator or designee and documented on the Safety-Monitoring Testing	S3110		

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S3110	Continued From page 7 form kept in a centralized location. The facility failed to provide supervision for this cognitively impaired, independently ambulatory resident, with a history of falls and leaving the facility unsupervised, which placed him/her in immediate jeopardy when he/she left the facility unsupervised. The facility abated the immediate jeopardy on 3/28/13 at 3:30 P.M. when the facility: 1. Assessed all residents living in the Reminiscence Neighborhood regarding their current behavioral status and risk of exhibiting exit seeking behaviors and assessed their appropriateness for the Reminiscence Neighborhood. 2. Updated the ISPs as necessary to provide guidance and direction to the care managers, including the development of strategies and interventions to minimize or prevent exit seeking behaviors. 3. Developed a monitoring program to daily check the functionality of the overall wander guard system and individual resident wanderguard devices were implemented with the Reminiscence Neighborhood Medication Aide or designee using the Resident Safety Systems Equipment Checklist and weekly oversight and checks by the maintenance Coordinator or designee using the Resident Safety Systems Equipment Checklist. 4. Provided comprehensive refresher training to the Reminiscence team members regarding how to respond to exit seeking/elopement behaviors, missing residents, and use of the new pagers. 5. The Executive Director or designee ensured that the staff perform the duties outlined in the Plan of Corrections, leads interdisciplinary team meetings and daily leadership meetings, to	S3110		

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S3110	Continued From page 8 ensure communication venues include discussion of residents exhibiting exit seeking or elopement behaviors. 6. The Executive Director or designee ensured that daily checks of the wander guard system occurred and testing and oversight was provided by the maintenance coordinator and the system remained functional. 7. The Executive director or designee will review, verify, and evaluate ongoing compliance with the Plan of Correction with the leadership team, including a review of the Plan of Correction during community Quality Assurance Meetings, and will initiate and implement corrective action if any variance or discrepancy occurs. The deficient practice remains at a scope and severity of a D	S3110		